Complete Summary

TITLE

Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS® 2009: Healthcare Effectiveness Data & Information Set. Vol. 1, Narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2008 Jul. 90 p.

National Committee for Quality Assurance (NCQA). HEDIS® 2009: Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2008 Jul. various p.

Measure Domain

PRIMARY MEASURE DOMAIN

Process

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the Measure Validity page.

SECONDARY MEASURE DOMAIN

Does not apply to this measure

Brief Abstract

DESCRIPTION

This measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. See the related National Quality Measures Clearinghouse (NQMC) summary of the National Committee for Quality Assurance (NCQA) measure Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who

had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

RATIONALE

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. According to a guideline developed by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, there is a need for regular and timely assessments and documentation of the patient's response to all treatments.

PRIMARY CLINICAL COMPONENT

Mental health; hospitalization; follow-up care

DENOMINATOR DESCRIPTION

Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year (see the "Description of Case Finding" and the "Denominator Inclusions/Exclusions" fields in the Complete Summary)

NUMERATOR DESCRIPTION

An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Evidence Supporting the Measure

EVIDENCE SUPPORTING THE CRITERION OF QUALITY

- A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
- A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences
- One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Overall poor quality for the performance measured
Use of this measure to improve performance
Variation in quality for the performance measured

EVIDENCE SUPPORTING NEED FOR THE MEASURE

National Committee for Quality Assurance (NCQA). The state of health care quality 2008: industry trends and analysis. Washington (DC): National Committee for Quality Assurance (NCQA); 2008. 131 p.

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Accreditation
Decision-making by businesses about health-plan purchasing
Decision-making by consumers about health plan/provider choice
External oversight/Medicaid
External oversight/Medicare
External oversight/State government program
Internal quality improvement

Application of Measure in its Current Use

CARE SETTING

Ambulatory Care
Behavioral Health Care
Managed Care Plans
Physician Group Practices/Clinics

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Advanced Practice Nurses
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Single Health Care Delivery Organizations

TARGET POPULATION AGE

Age greater than or equal to 6 years

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

- Mental illnesses affect about one in four adults.
- In 2004, suicide was the 11th leading cause of death in the U.S., accounting for over 32,000 deaths.

EVIDENCE FOR INCIDENCE/PREVALENCE

Centers for Disease Control and Prevention. Welcome to WISQARSTM (Web-based Injury Statistics Query and Reporting System). [internet]. Atlanta (GA): Centers for Disease Control and Prevention; 2008 Nov 18[accessed 2009 Mar 23].

Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry2005 Jun;62(6):617-27. PubMed

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

- Mental illnesses such as depression, bipolar disorder and schizophrenia are significant causes of disability.
- Mortality rates, primarily from suicide, are estimated to be over 4 percent for major forms of depression.
- Mental illness accounts for more than 15 percent of the overall disease burden in the U.S., more than the burden associated with all forms of cancer. Disease burden assesses the size of a health problem measured by cost, mortality, morbidity and other indicators and is expressed in terms of disability-adjusted life years.

EVIDENCE FOR BURDEN OF ILLNESS

Coryell W, Young EA. Clinical predictors of suicide in primary major depressive disorder. J Clin Psychiatry2005 Apr;66(4):412-7. PubMed

Larkin GL, Smith RP, Beautrais AL. Trends in US emergency department visits for suicide attempts, 1992-2001. Crisis2008;29(2):73-80. PubMed

National Institute of Mental Health (NIMH). Statistics. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2009 Mar 18[accessed 2009 Mar 23].

UTILIZATION

- A study showed half of first-time psychiatric patients were readmitted within two years of hospital discharge.
- In 2005, more than two million patients were discharged from a hospital with a mental disorder.

EVIDENCE FOR UTILIZATION

Cougnard A, Parrot M, Grolleau S, Kalmi E, Desage A, Misdrahi D, Brun-Rousseau H, Verdoux H. Pattern of health service utilization and predictors of readmission after a first admission for psychosis: a 2-year follow-up study. Acta Psychiatr Scand2006 Apr;113(4):340-9. PubMed

DeFrances CJ, Hall MJ. 2005 National Hospital Discharge Survey. Adv Data2007 Jul 12;(385):1-19. PubMed

COSTS

In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the U.S., the annual economic and indirect cost of mental illnesses is estimated to be $79 billion. In 1997, the latest year comparable data are available, the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illnesses. Mental health expenditures are predominantly publicly funded at 57 percent, compared to 46 percent of overall health care expenditures.

The economic burden of serious mental illness is estimated at $317 billion, which includes the cost of health services, loss of earnings and disability benefits.

EVIDENCE FOR COSTS

Insel TR. Assessing the economic costs of serious mental illness. Am J Psychiatry2008 Jun;165(6):663-5. PubMed

New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America. Final report. DHHS Pub. No. SMA-03-3832. Rockville (MD): U.S. Department of Health and Human Services; 2003.

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. Members must have been continuously enrolled from the date of discharge through 30 days after discharge with no gaps in enrollment.

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions

Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (refer to Table FUH-A in the original measure documentation for codes to identify mental health diagnosis) on or between January 1 and December 1 of the measurement year

Note:

Multiple discharges. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Mental health readmission or direct transfer. If the discharge is followed by readmission or direct transfer to an *acute facility* for any mental health principal diagnosis (refer to Tables MPT-A and MPT-B in the original measure documentation) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclusions

- Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.
- Exclude discharges followed by a readmission or direct transfer to a *non-acute facility* for any mental health principal diagnosis (refer to Tables MPT-A and MPT-B in the original measure documentation) within the 30-day follow-up period. These discharges are excluded from the measure, because readmission or transfer may prevent an outpatient follow-up visit from taking

place. Refer to Table FUH-B in the original measure documentation for codes to identify non-acute care.
- *Non-mental health readmission or direct transfer*. Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis. This includes any ICD-9-CM Diagnosis or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

RELATIONSHIP OF DENOMINATOR TO NUMERATOR

All cases in the denominator are equally eligible to appear in the numerator

DENOMINATOR (INDEX) EVENT

Clinical Condition
Institutionalization

DENOMINATOR TIME WINDOW

Time window follows index event

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions
An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Exclusions
Unspecified

MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

NUMERATOR TIME WINDOW

Fixed time period

DATA SOURCE

Administrative data

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Analysis by subgroup (stratification on patient factors, geographic factors, etc.)

DESCRIPTION OF ALLOWANCE FOR PATIENT FACTORS

This measure requires that separate rates be reported for commercial, Medicare, and Medicaid product lines.

STANDARD OF COMPARISON

External comparison at a point in time
External comparison of time trends
Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

Follow-up after hospitalization for mental illness (FUH).

MEASURE COLLECTION

HEDIS® 2009: Healthcare Effectiveness Data and Information Set

MEASURE SET NAME

Effectiveness of Care

MEASURE SUBSET NAME

Behavioral Health

DEVELOPER

National Committee for Quality Assurance

FUNDING SOURCE(S)

Unspecified

COMPOSITION OF THE GROUP THAT DEVELOPED THE MEASURE

National Committee for Quality Assurance's (NCQA's) Measurement Advisory Panels (MAPs) are composed of clinical and research experts with an understanding of quality performance measurement in the particular clinical content areas.

FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST

In order to fulfill National Committee for Quality Assurance's (NCQA's) mission and vision of improving health care quality through measurement, transparency and accountability, all participants in NCQA's expert panels are required to disclose potential conflicts of interest prior to their participation. The goal of this Conflict Policy is to ensure that decisions which impact development of NCQA's products and services are made as objectively as possible, without improper bias or influence.

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

1997 Jan

REVISION DATE

2008 Jul

MEASURE STATUS

This is the current release of the measure.

This measure updates a previous version: National Committee for Quality Assurance (NCQA). HEDIS 2008. Healthcare effectiveness data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2007 Jul. various p.

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS® 2009: Healthcare Effectiveness Data & Information Set. Vol. 1, Narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2008 Jul. 90 p.

National Committee for Quality Assurance (NCQA). HEDIS® 2009: Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2008 Jul. various p.

MEASURE AVAILABILITY

The individual measure, "Follow-up After Hospitalization for Mental Illness (FUH)," is published in "HEDIS® 2009. Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

COMPANION DOCUMENTS

The following is available:

- National Committee for Quality Assurance (NCQA). The state of health care quality 2008: industry trends and analysis. Washington (DC): National Committee for Quality Assurance (NCQA); 2008. 131 p.

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

This NQMC summary was completed by ECRI on June 30, 2003. The information was verified by the measure developer on July 25, 2003. This NQMC summary was updated by ECRI on June 16, 2006. The updated information was not verified by the measure developer. This NQMC summary was updated by ECRI Institute on April 11, 2008. The information was verified by the measure developer on May 30, 2008. This NQMC summary was updated again by ECRI Institute on March 20, 2009. The information was verified by the measure developer on May 29, 2009.

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